

Request for Information (RFI) #1574-DDES-SM

**Assessment of Reliability and Validity of
an Outcomes Measurement Tool for Adults with Disabilities
and Development of its Uses for Quality Control**

Issued by:
The State of Wisconsin
Department of Health and Family Services
Division of Disability and Elder Services

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Responses Requested by:
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Submit responses by mail to:
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Table of Contents

I. Purpose of this RFI	3
Effect of this RFI	3
II. Background	4
<i>Reasons for assessing personal-experience outcomes</i>	<i>4</i>
<i>Critical attributes of personal-experience outcomes</i>	<i>5</i>
III. Projected Uses of Personal-experience Outcome Interviews.....	5
IV. The information we are seeking.....	6
<i>Primary questions.....</i>	<i>6</i>
<i>Other Topics of interest to DHFS</i>	<i>10</i>
V. Preparing a Response	10
<i>Proprietary concerns</i>	<i>10</i>
<i>Questions about this RFI</i>	<i>10</i>
<i>Incurring costs.....</i>	<i>10</i>
<i>Submission Organization and Format</i>	<i>10</i>
VI. Submitting a response.....	10
Appendix A: Personal-experience outcomes for long-term care	11
Appendix B: The RFP for an Outcomes Assessment Method Development	14
DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION.....	20

I. Purpose of this RFI

The Department of Health and Family Services' long-term care programs for adults with disabilities and frail elders have adopted a set of 12 'Personal-Experience Outcomes' (see Appendix A) that are intended to become a strong element in both care planning and in quality management.

The Department has recently issued a Request for Proposals (RFP) to award a contract for the development of: 1) an interview tool for these 12 personal-experience outcomes, 2) instructions, 3) a training program, and 4) a method for assessing the competence or reliability of the trained interviewers. Some information about that RFP can be found in Appendix B. The RFP is currently posted on the Wisconsin VendorNet System.

The products of that contract (the 'development contract') will not include testing of the measurement tool to assess its reliability and validity. However, we are aware that such testing is necessary to support its utility for quality-management purposes and would likely enhance its value for care-management purposes. The products of the development contract also do not include development of methods for compiling the information from the interviews and using them for quality-management purposes.

At the current time, the Department does not have funds to perform reliability and validity testing of the tool that will result from the development contract. We do, however, intend to seek that funding as soon as possible. **With this Request for Information (RFI), the Department is seeking information that will help us to develop:**

- **An RFP for a project to test the reliability and validity of the outcomes-assessment tool that will be created in 2007 and to develop methods for using its results in quality management; and**
- **a budget estimate for that project.**

Effect of this RFI

This request is not a solicitation for proposals, bids or services, nor does it represent any other formal procurement device. No contract will be awarded on the basis of this RFI.

Responses to this RFI will have no effect on the award of the contract that will result from responses to State of Wisconsin RFP # 1571-DDES-SM.

Information included in the responses to this RFI may be used to seek funding for validity- and reliability-testing of the outcomes-measurement tool that will be created in 2007, and to inform for the development of future RFP that will seek a vendor to carry out that testing. However, no vendor who responds to that future RFP will be advantaged or disadvantaged by their response or lack of response to this RFI.

Response to this RFI will in no way obligate either the interested entity or the Department of Health and Family Services.

II. Background

Reasons for assessing personal-experience outcomes

Objectively verifiable health, safety, and functional status outcomes are and always will be among the intended results of both long-term care and limited-term medical care. Assessment methods for these outcomes are relatively well established and are used in both long-term and acute medical care, for both care planning and quality management.

However, because long-term care continues over the course of a person's lifetime, it has a greater potential for either enhancing or impairing a person's quality of life. Intentionally or unintentionally, long-term care can support or impair people's ability to live where they feel comfortable, hold the jobs that they are capable of holding, participate in the community, and develop friendships and maintain relationships with family members. Poor-quality long-term care limits and constrains a person's options in these areas; high-quality long-term care supports a person's ability to live his or her life consistent with his or her desires and abilities.

As a result, those who seek quality in long-term care must attend to a broad set of quality-of-life results—results that are beyond and in addition to clinical and functional outcomes. These outcomes must be woven into the operations of the programs, in three important ways:

1. Assessing each individual's desired personal-experience outcomes as part of his or her assessment and care-planning process (that is, determining what personal-experience outcomes are desired as part of his or her quality of life and to what extent those outcomes are present in the person's life). The long-term care program standards and contract language requires that a person-centered assessment and subsequent service plan development be based upon individually identified personal-experience outcomes;
2. Ensuring that quality-management efforts discover the extent to which person-specific personal-experience outcomes are identified and achieved, which will be the cornerstone of overall quality monitoring and continuous quality improvement efforts of both the Department of Health and Family Services (DHFS) and the local care-management agencies; and
3. Reporting the program's performance in achieving personal-experience outcomes to the program's stakeholders.

Although assessing quality-of-life outcomes may be more difficult and less objective or empirical than, for example, assessing physical health status, personally experienced quality of life can be assessed in a rigorous and reasonably reliable way. In fact, if long-

term care professionals are to devise or assist consumers of long-term care in devising plans of care that truly support and do not interfere with consumers' desired personal experience of their own quality of life, ways to reliably assess personal-experience outcomes must be identified.

Critical attributes of personal-experience outcomes

First, they focus on *personal experience*. Anyone can ascertain or even dictate the recreational activities of any other individual, but only the person who participates in the recreation can judge whether those activities enhance his or her quality of life. Similarly, others might ascertain or decide when and what an individual eats, but only the person who is eating can judge his/her personal experience of the meal. A dream job for one person might be insufferable for another; it is the subjective personal experience of the job that determines whether it contributes to quality of life. A situation that one person experiences as welcome and restful privacy might give another person an experience of frightening isolation.

Second, they are *outcomes*. They are conditions or circumstances that are of value to the individual in and of themselves, rather than as means to ends. They do not describe the quality of services or the even the level of satisfaction with services; they describe the quality of life.

As such, personal-experience outcomes sometimes include circumstances that cannot be attained through the provision of even the highest-quality long-term care services. For example, the death of a beloved life-partner will unavoidably impair the survivor's sense of continuity and security in his or her life. However, providers of high-quality long-term care can continue to support continuity and security in other ways and possibly help to prevent additional avoidable negative consequences.

III. Projected Uses of Personal-experience Outcome Interviews

At this point, we can identify only one certain use of the personal-experience outcome interview tool: the Department will almost certainly require the External Quality Review Organization (EQRO) to use the interview tool with a small sample of members during the course of their annual site visits to managed-care organizations. Currently, approximately 12,600 Wisconsin residents are members of these managed-care organizations, but that number is likely to grow rapidly with managed-care expansion. However, the number of people interviewed each year by state or EQRO staff for quality-monitoring purposes is unlikely to exceed 500 and may not reach that for reasons of cost and staff availability.

The second most likely use of the interview tool will be by the managed-care organizations, in the course of assessing their members' needs and desired outcomes as a basis for care planning. Although the Department will continue to require the managed-care organizations to provide their members with person-centered care plans (which

require some assessment of the members' desired outcomes), the Department has not decided—in fact, has not given serious consideration to—requiring the use of the new outcomes-assessment tool in all managed-care care plans. However, once a standardized tool for assessing outcomes becomes available to the managed care organizations, we believe that many will voluntarily incorporate it into their routine assessments, for two reasons. First, several managed care organizations have expressed a strong interest in using a standard outcomes-assessment method to facilitate training and supervision of care managers in outcomes-based care planning, high-quality care plans, and comparison of their work with other MCOs. Second, MCOs will want to assess their own performance using the same method that will be used by the EQRO.

The Department has not yet determined other uses for the outcomes-assessment tool that will be developed in 2007. It is likely that some county fee-for-service waiver programs will make use of the tool, and possible that one or more of the major statewide waiver programs will use the tool in their quality-review efforts.

At both the state and local level, managers and program administrators are deeply committed to support of quality-of-life outcomes as the essential mission of the long-term care programs. As a result, there is strong interest in eventually developing and implementing the outcomes-assessment interview tool to the point where compiled results could be used for quality-management purposes more sophisticated than simple feedback to the MCOs—uses such as analysis of results for different subgroups within the long-term care population and pay-for-performance initiatives.

IV. The information we are seeking

Primary questions

Question 1: What types of validity would it be beneficial for the Department to establish for this interview tool, and how might these be established?

'Validity' is the extent to which the interview method actually measures that which it is intended to measure. The personal-experience outcomes interview is intended to measure the subjective experience of quality of life, which all of us know is a 'real thing' that is associated with high-quality long-term care.

However, though real, personal-experience outcomes are inherently subjective. Anyone can ascertain whether another person is, for example, going to church every weekend, but only the churchgoer can ascertain whether the experience is satisfying and meaningful or tell whether a different sort of weekend respite would be more satisfying. This inherently subjective nature of personal-experience outcomes presents special challenges for validity.

Another validity challenge is the fact that there are few—perhaps no—other available existing tools that purport to measure the subjective experience of

quality-of-life. We know of few other yardsticks against which we will be able to compare the results of personal-outcomes experience interviews.

Nevertheless, the outcomes-assessment tools used in Wisconsin up to this point seem to have all had reasonable levels of face validity and content validity, judging by the level of acceptance they have received from the people familiar with them, including the consumers who have been interviewed. Construct validity, which is often established by comparing the results of one measure to those of another measure that is recognized as valid, has not been established with these tools.

It may be possible for the interview tool to gain widespread acceptance and clear utility without extensive testing of its validity, or it might be that there are some types of validity that could be tested and established that would enhance the utility and the acceptance of the interview tool.

In the responses to this RFI, we are asking for discussions of the types of validity that could be established for this interview tool; the methods by which that validity could be assessed, and the estimated cost of establishing validity using those methods, and the benefits that might be obtained by establishing validity in those ways.

Question 2: What level or levels of reliability are appropriate for the intended uses of this interview tool?

‘Reliability’ of the measurement method is the degree to which the tool produces the same result when situations are the same. While it is safe to say that more reliability is always better than less, the same degree of reliability is not needed for every assessment tool, or for every use of the same tool.

For example, a high school student might take the SAT mathematics skills assessment, a test that has a high established reliability to support its use across many school districts and as a basis for college admissions and scholarship awards. The same student might, at the beginning of the school year, have had her math skills assessed by a test that was devised and administered by her algebra teacher for the purpose of discovering each student’s weak and strong skills.

While the algebra teacher’s test would have needed a certain minimum level of reliability to be of use, it would not have needed the same degree of demonstrated reliability as the SAT assessment, nor would the teacher have needed to forego assessing his pupils’ skills because his test was not as reliable as the SAT.

Because Wisconsin intends to use the outcomes-assessment method for several purposes, the degree or level of reliability needed for the assessment method is not immediately clear.

At the low end of the need for reliability, we suspect, is the use of the interview tool by individual care managers working with individual consumers. If the interview tool provides each care manager with a framework that ensures that he or she consistently has productive discussions with members that cover an adequate and fairly standard content area, the tool will likely have served its purpose of supporting reliably high-quality member-centered assessments.

At the high end of the need for reliability might be the use of the results of the outcomes interviews as a basis for providing performance-based rewards or sanctions to managed-care organizations, a practice known as ‘pay for performance.’

In between, intended uses of the interview tool include: obtaining information to provide to care managers as useful feedback on the success of their care plans; gathering evidence to be used in concert with other performance indicators to identify possible problem areas for further investigation or to generally assess the quality of care in a managed care organization; and providing data that can be compiled in reports to stakeholders.

In the responses to this RFI, we are asking for discussions of how the Department could usefully approach assessing the reliability of the outcomes-interview tool. Is it possible to assess reliability of a single tool in such a way that we can establish its sufficiency for one use separate from its sufficiency for another? Would reliability testing need to be carried out several times, or need to be repeated at certain intervals, or would it be possible to establish the tool’s reliability once?

In addition, we are looking for preliminary descriptions of the activities necessary—and the estimated cost of those activities—that would be advisable to complete the recommended reliability testing.

Question 3: How could the Department collect and aggregate interview results to be useful for stakeholder reporting and performance measurement?

The Department will develop a small, well-trained and reliable group of interviewers who will, as part of state-level quality-monitoring efforts, conduct a limited number of outcome interviews in each managed-care organization each year. We are confident that we can devise ways that these interviewers can provide useful feedback to the individual care managers and to their supervisors and managers regarding the quality of care that their members are receiving.

However, the Department also has strong interest in being able to compile aggregate data depicting the achievement of personal-experience outcomes. When the Family Care program consisted of only five managed-care organizations, the Department could conduct approximately 500 interviews each year and, with a reasonable degree of statistical significance, compile data on the achievement of outcomes by managed-care organization and by target group. (We did not believe

that we had enough data, however, to accurately measure achievement by target group within any single CMO, with the exception of frail elders in Milwaukee.)

The Department has not yet decided the number of interviews that will be conducted by state-level quality reviewers, after we develop the new assessment tool. However, as the managed-care program expands, we suspect that interviews of a statistically valid sample of members in each local care-management organization in each target group—conducted by state quality reviewers—would place an unacceptable burden on the local agencies, the consumers, and the Department’s quality-management budget.

However, in much the same way that the Department now relies on the local agencies (resource centers, care-management organizations, and county waiver programs) to administer the functional screen and to submit the results to the State, the Department is contemplating the possibility of relying on the results of outcomes interviews conducted by the local agencies as a source of data that can be aggregated and analyzed.

If DHFS is to collect and compile outcomes-assessment information submitted by the local agencies, we will need to conduct some sort of ‘validation,’ or look-behind, to verify that the information is being collected in the prescribed manner (so that it can be aggregated) and that it is being reported accurately (so that it can be trusted). Quality review staff at the Department or any federally qualified external quality review organization with which the Department might contract will be familiar with the concept and processes of validation, but the challenges of validating data collected through oral interviews are daunting. On the other hand, reviewing the work of the care managers to ensure that they can perform this particular task well has value beyond simply validating submitted data; the feedback that such a validation process would generate for the care managers would help them in performing their core function better.

In the responses to this RFI, we are asking for discussion of the potential benefits and difficulties of developing methods to enable the use of aggregate data on personal-experience outcomes in quality management and in stakeholder reporting. We will use these discussions to inform internal discussions on seeking funding for, and issuing an RFP seeking a vendor for, development of these methods. For example, we are interested in the following possibilities:

- Methods of selecting the sample of members to be interviewed by state quality reviewers that provide the best advantage for both state and local quality-management efforts.
- Methods of reporting the results of personal-experience outcome results from managed-care organizations to the State in ways that can be aggregated and analyzed;

- Methods of validating personal-experience outcome results reported by the managed-care organizations; and
- Methods of compiling or aggregating results reported by either care managers or quality reviewers, or both, for the purposes of performance assessment and stakeholder reporting.

Other Topics of interest to DHFS

Respondents to the RFI are invited to submit additional information, comments, or recommendations related to material addressed in this RFI.

V. Preparing a Response

Proprietary concerns

If responders have proprietary concerns, a Designation of Confidential and Proprietary Information form (DOA-3027) is attached. The form may be completed and submitted with your response.

Questions about this RFI

All questions must be in writing and must be submitted before November 17 via e-mail to mckimk@dhfs.state.wi.us. No phone or faxed questions can be acknowledged.

The Department shall respond to all vendors' questions via email and posting to VendorNet and the Department's web site within three business days of inquiry.

Incurring costs

The State of Wisconsin is not liable for any cost incurred by vendors in replying to this RFI.

Submission Organization and Format

Respondents may address any one or all of the questions posed in this RFI. No specific organization of the response is prescribed. Responses should be submitted in both paper copy and on a CD, as a Microsoft Word document or a pdf file.

VI. Submitting a response

Please submit your responses by December 4, 2006 to:

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Division of Disability and Elder Services
Department of Health and Family Services
PO Box 7851
Madison, WI 53707-7851

Appendix A: Personal-experience outcomes for long-term care

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of our long-term care system. The following statements and definitions demonstrate the areas of life that people in long-term care programs have identified as being important to their quality of life. They are stated in the first person to emphasize the importance of the personal voice and experience of the individual. These statements provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs.

CHOICE

When people participate in human service systems, they often feel a loss of control over their lives as professionals or others in authority get involved. In our long-term care system we strive to empower the individuals who receive services (participants, members, or consumers) to have choices—to have a "voice" or say about things that affect their quality of life and to make decisions as they are able. People with cognitive disabilities are supported to actively participate in the ways they are able, and their decision-makers (guardians or POA) keep their perspectives in mind for making decisions. The following statements reflect some of the ways in which the system can help support people to maintain control over their lives.

I decide where and with whom I live.

One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.

I make decisions regarding my supports and services.

Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.

I decide how I spend my day.

Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible.

PERSONAL EXPERIENCE

A person's day-to-day experience should meet his or her expectations of a high quality life. People who participate in a long-term care programs need to feel they are 'citizens', not parts of a 'program' and that they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take them over or get in the way of the experience.

I have relationships with family and friends I care about.

People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.

I do things that are important to me.

My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.

I am involved in my community.

Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.

My life is stable.

My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me (paid and unpaid) is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I think I am reasonably well prepared.

I am respected and treated fairly.

I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.

I have privacy.

Privacy means that I have time and space to be by myself or with others I choose. I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me a sense of dignity.

HEALTH and SAFETY

Health and safety is an essential and critical part of life that can affect many other areas of a person's life. The following outcome statements represent the person's right to

determine what is important to him or her in these areas, and what risks he or she is comfortable with. It's about what the person feels he or she needs to meet personal priorities. It is not an assessment of whether or not the person's circumstances meet others' standards for good health, risk, or safety.

I have the best possible health.

I am comfortable with (or accepting of) my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to me to make informed decisions about my health.

I feel safe.

I feel comfortable with the level of safety and security that I experience where I live, work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, I have access to those that can support me in making those determinations.

I am free from abuse and neglect.

I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.

Appendix B: The RFP for an Outcomes Assessment Method Development

Number: State of Wisconsin RFP # 1571-DDES-SM

Title: Development of Methods and Training for Assessing Personal-Experience Outcomes for Adults with Developmental or Physical Disabilities and Frail Elders in Wisconsin's Medicaid-Funded HCBS and Managed Long-term Care Programs

Released: September 27, 2006 through VendorNet

Contract to be awarded:

Term: November 27, 2006 – December 31, 2007

Amount: \$300,000

Deliverables:

All deliverables from the contract awarded through RFP# 1571-DDED-SM (the 'Development RFP') will be in the public domain; the contractor will retain no exclusive rights related to their reproduction, distribution, use, or revision.

The contract awarded through that RFP (the 'Development contract') will produce four deliverables:

1. An interview tool for eliciting personal preferences and priorities for each of the 12 outcomes, with unique but related versions for:

- Elders who are frail who also possess cognitive and language-based communications abilities,
- Adults with physical disabilities who also possess cognitive and language-based communications abilities;
- Adults who are developmentally disabled who also possess cognitive and language-based communications abilities; and
- Adults who have severe cognitive limitations and who are without language-based communication abilities. (Typically these persons communicate both through alternatives to language means and with the assistance of a designated proxy).

To ensure that the outcomes identified truly reflect those which are individualized and personal-experience based, we expect that the interview tool will need to take the form of a discussion guide rather than a set of required or standardized questions.

Existing interview tools with elements of this type that are currently used in Wisconsin are the Community Options Program (COP), the Developmental Disabilities Section's tool (PROACT) and the Recovery-oriented Systems

Assessment (ROSA) tool¹, outcome-assessment tool used by quality reviewers in the community mental-health programs. In the past, the other waiver programs have used similar tools and also those based in person-centered planning on occasion.

The need for a discussion-type interview rather than a set of standard questions stems from several causes. First, few individuals understand what an ‘outcome’ is as the term is used in long-term care. Care managers have found that asking consumers straightforward questions about what they hope to get out of long-term care tends to yield requests for specific services or goods. More directed questioning is needed to draw a discussion of the things that truly constitute quality of life for each person individually.

Second, each of the 12 outcomes is a high-level statement that contains more specific elements (see Appendix A), so that conversations are necessary to explore the underlying content. The individual’s unique preferences for each outcome must be solicited to determine whether the high-level outcome is present for that person (e.g., what is it about this living situation that makes it desirable to the individual? What does the individual want to do in the community, if anything?) This need to ascertain preferences specific to each individual rules out the use of standardized survey-type questions.

Third, care managers need conversational interviews for the additional purpose of assessing the relative importance each consumer places on the various desired outcomes. The individual’s strength of preference must be solicited if the care manager is going to be able to set appropriate priorities in the care planning process. Rarely does a care plan need to support all 12 outcomes actively, and some sequencing is often necessary to represent the individual’s priorities. For example, an unstable health issue might need to be resolved before community participation can be at the level the person desires. Likewise, the care manager needs to understand the person’s preferences for outcomes that currently seem unimportant. These outcomes might not be important to the consumer either because the consumer genuinely does not have a preference, or because the consumer has a preference that is currently achieved. The effective care manager understands priority ranking of personal-experience outcomes from the perspective of the individual consumer; it is essential for the process to remain driven by the individual’s desires and preferences.

While being conversational, the interviews must also have a basic consistency of content with regard to the underlying elements of the high-level outcomes. Consistency is typically promoted by increasing the amount of structure in the measurement and reducing the amount of interviewer judgment required. However, we are seeking a discussion-based interview tool appropriate to the

¹ http://dhfs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY_2005/2005-21appendixB.pdf

infinite variety of individual preferences for these outcomes. Most of the outcome interview tools that have been used by DHFS HCBS programs include suggested interview questions to elicit consistent, comparable information from the individual, and a second set of standardized questions to guide the interviewer's determination as to whether the outcome is present.

Another challenge to reliability is the subjective nature of the information the interview is intended to discover—the interview seeks to discover how each person feels about things such as his or her job, safety, roommate and health. Moods and temporary setbacks can affect feelings, but the interview tool will need to help the interviewers discover a general ongoing level of satisfaction with the various components of quality-of-life.

Although this general set of outcomes is intended to describe quality of life for all target groups and all individuals, separate versions of the tool are needed for the different target groups. For some outcomes, the desired results are likely to be different enough to merit at least a slightly different discussion guide. For example, although meaningful activities are a part of every individual's quality of life, interviews with adults with physical disabilities are more likely to focus on employment issues in this area than are interviews with elders who are frail. Similarly, although physical health is a part of every individual's quality of life, discussions about physical health with elders who are frail are likely to have a different focus than interviews with adults with development disabilities who may be in early adulthood.

To ensure its validity with all members who are served by these long-term care programs, the interview tool will also need specific questions and interviewing techniques for persons with serious cognition difficulty and/or language based communication difficulty. Clearly articulated and explained methods for working with this target group are a key to the ultimate acceptance and credibility of personal-experience outcomes measurement, both as a basis for care planning and also quality management.

2. Instructions for the conducting, recording, and scoring of interviews

The interview tool will need a manual—a set of clearly written instructions—for its administration, recording, and scoring.

The first purpose of clearly written instructions is to support consistent administration of the assessment method among interviewers and over time. While classroom training and consultation with experts are necessary, experience in Wisconsin has shown that much of the care managers' on-going skills-building is gained on the job and through collaboration with colleagues. Care managers must be able to learn from, and later refer to, accessible, normative written instructions if they are to develop their own skills and consult with their co-workers.

The second purpose of clearly written instructions is to support use of the interviews' results by quality managers and stakeholders. Wisconsin's experience has shown that it is important for those who will be relying upon the results of the interviews, particularly quality managers and external stakeholders, to be able to understand how the information was collected and what it represents. An assessment method that is a 'black box' presents a barrier to those who seek to understand and to act upon the information it provides. Instructions for the interviews must be well-written, clear, and readily available to all interviewers and stakeholders.

The interview will need to lead to the creation of nominal variables (e.g., the outcome is present/is not present, or is being supported/does not now need support/is not being supported) that can be aggregated among interviews or compared over time (e.g., last year, the consumer had eight outcomes present; this year, he has ten.) Therefore, the interview tool will need to have clear methods and instructions for transforming the information gathered in interviews into nominal variables that are clear enough to support reasonable consistency between co-workers and also those in different agencies. Instructions need to differ somewhat depending on whether the tool is used for assessment and care planning or quality review.

While we expect only one tool, there will be several versions. As such, instructions on tool use will likely need to differ somewhat for assessment and care-planning uses and overall quality management use.

Care managers will be administering the interview, in most cases, to people with whom they have ongoing relationships, while quality reviewers will usually be administering the interview to people they have met through that interview.

Care managers will use the interview tool as just one part of a broader assessment process, and so should be able to administer the interview in either a single sitting or over several meetings, depending upon the member's needs, preferences, or schedule. Quality reviewers, on the other hand, will usually need to administer the interview within a single episode, extending it to two meetings only when necessary.

Care managers need to record individual preferences in more detail than quality reviewers, in order to provide quality assessments and service planning; quality reviewers will need to record information that is useful for feedback to care managers as a part of the larger scheme of quality improvement.

Local care-management agencies have expressed significant interest in the possible development of an automated method of reporting the results of personal-experience outcomes interviews, possibly associated with the

Department's web-based Long-Term Care Functional Screen² (LTC FS). While the eligibility and level-of-care-determination function of the Long-Term Care Functional Screen must remain inviolate, we are interested in a method of recording and reporting the results of the personal-experience outcome interviews that could be automated, perhaps in a discrete application closely associated with the Long-Term Care Functional Screen, but clearly separate from the LTC FS.

3. Training program and materials for care managers and for quality reviewers

Experience in Wisconsin has demonstrated the need for strong and effective training in outcomes assessment, and the Department is developing training in the basic concepts and skills needed to identify personal-experience outcomes and incorporate them in care planning.

Assessing personal-experience outcomes is a highly complex skill, and training must continue over time, with the interviewers having the opportunity to gain information, practice, receive feedback, and improve. Interviewers' skills will tend to 'drift' over time as they forget or unconsciously re-interpret things they learned in training, and interviewers will continually be encountering novel situations. Therefore, the training program needs to include not just curriculum materials, but a recommended sequence of learning, practicing, feedback, and consultation. It is also necessary that the training program provide managers and supervisors of the interviewers a certain level of understanding, so that they can support the interviewers in their task.

The training program will need to differ somewhat for care managers and for quality reviewers, who will be using the interview tools for slightly different purposes. For example, care managers will need to integrate the results of the outcomes interviews into assessments and service planning, while quality reviewers will need a level of reliability which is able to be established in perhaps just one interview which will provide feedback to overall quality management considerations. Skills training specific to the role of the quality reviewers other than the care managers should be a part of the training.

It is important to remember that care managers are trained by the local agencies to perform assessments and complete long-term care planning, so the outcomes-assessment training for care managers will be, at a minimum, a responsibility shared by the Department and the local care-management agencies.

The development contract will design, create, test, assess, and revise a training program and materials that will, at the end of the contract, leave the Department and local long-term care management agencies with the ability to carry on that training. The development contract will not include the delivery of training

² <http://dhfs.wisconsin.gov/LTCare>

beyond the life of this contract. We are aware that the planned schedule for the contract, ending in December 2007, is quite limited in relation to the time usually needed for developing, testing, revising, and retesting a training program, and are aware that the project may not be as complete as desirable in December 2007, in which case, it will need to leave the Department with a clear plan for additional necessary activities.

4. A method for assessing interviewers' reliability in administering the outcomes interview

In the past, the Department has used outcomes-assessment methods with varying degrees of rigor in the steps taken to ensure that interviewers reliably administer the interview over time or to different individuals. Among the techniques that could be used, separately or in combination, to assess the competence or reliability of interviewers are statistical analysis of interviewers' findings, observations of interviews by expert interviewers, or prompt re-interviewing of a small number of interviews by an expert.

It is likely we will want the reliability-testing for care-managers and for quality-reviewers to differ somewhat. Because the administration of these interviews by care managers is intended to be an ongoing part of every initial and ongoing assessment, the process used for assessing interviewer reliability will, in practice, be one part of the quality management system for assuring the quality of the care manager assessments and service-planning. Quality reviewers, who will fulfill a role of validating results of some of the care managers' interviews, will likely need a higher standard of reliability.

Finally, the measurement of interviewers' reliability will need to be an ongoing endeavor, and we are expecting that development, testing, and refinement of reliability-testing methods cannot be carried out to the full extent desirable during the contract period. Therefore, the development project will also need to leave the Department with instructions and guidance regarding the ongoing efforts that will be needed to establish and improve inter-rater reliability over time.

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The attached material submitted in response to RFI # _____ includes proprietary and confidential information which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or is otherwise material that can be kept confidential under the Wisconsin Open Records Law. As such, we ask that certain pages, as indicated below, of this bid/proposal response be treated as confidential material and not be released without our written approval.

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We request that the following pages not be released:

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